Health Board Elections and Alternative Pilots: Literature Review

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HEALTH BOARD ELECTIONS AND ALTERNATIVE PILOTS: LITERATURE REVIEW

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The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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1 EXECUTIVE SUMMARY

1.1 The Health Boards (Membership and Elections) (Scotland) Act 2009 introduced pilots of direct elections to two Scottish Health Boards. As part of the evaluation of the pilots, this literature review was undertaken to gather evidence on a range of options used internationally to enhance public representation on Health Boards. In Scotland, the pilot elections are the latest in a series of measures which have aimed to increase public involvement and accountability in NHS decision-making. Measures introduced by previous administrations include a statutory duty for Boards to involve the public in decision-making, encouraging Boards to establish Public Partnership Forums, the inclusion of representatives of Local Councils on Boards, and establishing the Scottish Health Council to support engagement with the public. Since 2007, as part of the agenda for a mutual NHS set out in *Better Health, Better Care* (The Scottish Government, 2007), the Government has introduced the Participation Standard to improve the collection of information on good practice and promote it, and increased opportunities for members of the public to ask questions at their Board's Annual Review event.

1.2 This literature review presents research evidence on methods of improving public representation on Health Boards: direct elections, alternative modes of appointment, and advisory committees. While there is a substantial literature on these topics, it does not necessarily offer evidence neatly packaged to inform policy-making. As others have acknowledged (Barnett & Clayden, 2007), the primary research on Board elections mostly focuses on the views of Board members and so it is difficult to identify wider impacts. This reflects a broader preoccupation in the literature with accounts of process rather than assessments of outcomes (Mitton, Smith, Peacock, Evoy, & Abelson, 2009). Even where research looks at outcomes, the absence of objective measures of community engagement, and the problems with attributing outcomes to specific initiatives, mean that conclusions are rarely as clear as we might like (S. J. Lewis et al., 2001).

1.3 The most directly comparable examples of direct elections to health bodies are some Canadian Regional Health Authorities (RHAs), New Zealand District Health Boards (DHBs), and Foundation Trusts in England. Evidence from these systems suggests that elections are not in themselves sufficient to ensure a high quality or quantity of public involvement.

- Low electoral turnout was a challenge for both Foundation Trusts and Canadian RHAs, although turnout has been higher for DHBs in New Zealand.
- Some Canadian provinces also had insufficient numbers of candidates, while in New Zealand candidate numbers have fallen but remained viable. There is some concern that candidate numbers for Foundation Trusts are on a downward trend.
- Elections do not guarantee a more descriptively representative group of Board members. In New Zealand, the continued appointment of a minority of Board members is intended in part to ensure adequate representation of minorities.

However, fears that elected Boards will harm health services due to a lack of experience or to 'political interference' do not appear to have been realised.

- Many voters seem to value health service experience more than finance or management skills when choosing candidates. Accordingly many elected Board members have a steep learning curve around financial and management issues.
- The role of Board Chairs in supporting learning has been found to be of critical importance in each case.
- Once in place, elected Board members have similar views to appointed Boards. There was no clear evidence that fears about the politicisation of Boards were realised in the three examples discussed.
- The more public role of elected Board members can raise expectations about the degree of influence they have. Boards often focus mainly on day-to-day management, with strategic policy-making remaining with central or provincial Government. In both New Zealand and Canada elected members were frustrated by these limitations on their influence.

Where elections have been tried and then abandoned, as in Saskatchewan, it has generally been justified by reference to low turnout and financial cost, rather than to evidence of problems with Board functioning.

1.4 One alternative to elections is to alter how Board members are recruited and appointed. There is a lack of research evidence on these techniques, but models which have been used include:

- Quotas (Quebec hospital boards in the 1970s, New Zealand District Health Boards) or targets (Primary Care Trust Boards in England) for the representation of particular groups on Boards.
- Rethinking advertising campaigns and supporting 'near hit' candidates to reapply (Primary Care Trust Boards in England)

1.5 There are many examples of advisory bodies in the UK and in Canada, including Scotland's current system of Public Partnership Forums. These are more thoroughly researched, particularly in the UK. Some themes from the literature include:

- Advisory bodies are sometimes criticised for being weak, as by definition they don't have direct decision-making control. It can be difficult to evaluate their level of influence.
- As with appointed Boards, questions of representation arise repeatedly with advisory bodies. People with the confidence and time to take part are often older, and more middle class. Ethnic minorities and young people are often under-represented. Models of 'drop-in drop-out' participation such as LINks in the English NHS are seen as a solution to this, but have other drawbacks.

1.6 International experience shows that neither elected nor advisory bodies can resolve all of the challenges of patient and public involvement; problems of low or intermittent engagement, questions about representativeness, and the cost-effectiveness of any given strategy are common and do not seem to have any one solution.

2 AIMS, METHODOLOGY AND LIMITATIONS

2.1 In theory, the accountability of health care providers in National Health Service systems is clear: it runs to the minister, who is in turn accountable to the legislature, which is in turn accountable to voters. However this has not always been perceived as successful in practice, and the history of the NHS shows repeated attempts to strengthen the links between local health care providers and members of the public.

2.2 The Health Boards (Membership and Elections) (Scotland) Act 2009 introduced pilots of direct elections to two Scottish Health Boards, and piloted two alternative models of appointing members in an additional two Health Boards. As part of the evaluation of the pilots, this literature review was undertaken to gather evidence on a range of options used internationally to enhance public representation on Health Boards. It presents research evidence on three methods of improving public representation on Health Boards: direct elections, alternative modes of appointment, and advisory committees.

2.3 In Scotland, the pilot elections are the latest in a series of measures which have aimed to increase public involvement and accountability in NHS decision-making. Measures introduced by previous administrations include a statutory duty for Boards to involve the public in decision-making, encouraging Boards to establish Public Partnership Forums, the inclusion of representatives of Local Councils on Boards, and establishing the Scottish Health Council to support engagement with the public. Since 2007, as part of the agenda for a mutual NHS set out in Better Health, Better Care (The Scottish Government, 2007), the Government has introduced the Participation Standard to improve the collection of information on good practice and promote it, and increased opportunities for members of the public to ask questions at their Board's Annual Review event.

3 CONCEPTUAL OVERVIEW OF PUBLIC INVOLVEMENT

3.1 The evidence on public involvement comes from a variety of health systems and from the 1960s to the present day. Terminology varies across time and health systems. This section discussed three dimensions of public involvement. How can we categorise and what do we call the activities undertaken? Who should be involved through public involvement? What do policy-makers seek to achieve by involving the public?

What?

3.2 One study of cancer patients, cancer service staff and Health Board Chief Executives in Scotland found that involvement suggested very different activities to different people, including

- Patient satisfaction questionnaires
- Health professionals' knowledge of their patients' problems
- Patients attending group sessions for support
- In the case of Chief Executives, 'getting the message across' to the public (Forbat, Hubbard, & Kearney, 2009).

The evidence base in this area is confused by the range of overlapping and sometimes ill-defined terminology. Since the 1960s there have been attempts to step back from the policy terminology of particular innovations and offer frameworks that categorise and assess activities. One of the best known conceptual models in this area is Arnstein's (1969) 'ladder of participation', which sought to distinguish activities which offered genuine empowerment, from those which were tokenistic or manipulative. Charles and Di Maio (1993) offered a simpler model. More recently, the concept of 'co-production', defined as "active involvement of the public in policy decision and/or service design/delivery" (S. Martin, 2009) has become more popular as a goal than ideas of citizen control.

Author	**Arnstein (1969)**	**Charles & Di Maio (1993)**	**Rowe & Frewer (2005)**	**Martin (2009)**
Concept	**'citizen participation'**	**'lay participation'**	**'public engagement'**	**'public engagement'**
Levels	manipulation			
	therapy			
	informing		public communication	information
	consultation	consultation	public involvement	consultation
	placation			
	partnership	partnership	public participation	co-production
	delegated power			
	citizen control	lay domination		

Table 1: Models of participation

3.3 More recent work has questioned the relevance of these hierarchies. Tritter and McCallum (2006, p. 165) reject Arnstein's ladder metaphor and propose instead a mosaic, arguing that

> *"A linear, hierarchical model of involvement… fails to capture the dynamic and evolutionary nature of user involvement. Nor*

does it recognise the agency of users who may seek different methods of involvement in relation to different issues and at different times. Similarly, Arnstein's model does not acknowledge the fact that some users may not wish to be involved."

Some commentators have cautioned against a 'more is better' approach, focused solely on progressing 'up the ladder'. Several empirical studies have explored patients' preferences for involvement in different types of decision-making, finding that 'citizen control' may not appeal to all, or even most, of the population (Litva, Canvin, Shepherd, Jacoby, & Gabbay, 2009; Litva et al., 2002; Thompson, 2007). Church *et al* (2002) argue that 'citizen governance' type roles with time-consuming responsibilities appeal to a very small section of the population. They argue that more meaningful participation can take place "outside of the boardroom". A helpful distinction in the Canadian literature is between citizen engagement (where authorities engage with the public to find out their preferences and needs) and citizen governance (where members of the public become part of the authority, taking on the work and responsibility of running a service) (Church, et al., 2002).

Who?

3.4 This literature review focuses on involving people as residents of a geographical area. Many (if not most) will be past, present or future service users, but their entitlement to be involved comes from their status as a member of the public. Public involvement activities have tended to attract participants from particular sections of the population, which can lead to concerns that only "the usual suspects" are involved (House of Commons - Health Committee, 2007). A 'catch 22' situation can arise where participants are expected to be both 'ordinary' members of the public and extraordinarily able to understand the complexities of public service management (Learmonth, Martin, & Warwick, 2009).

3.5 Such concerns are often expressed as being about representation. Pitkin's (1967) account of representation explains the distinction between different types. For present purposes the most relevant types are:

- Formal representation: representation requiring formal acts of authorisation (for example by election) and accountability (for example by regular re-election).
- Descriptive representation: representation requiring that those people representing the public exactly resemble them in (demographic) characteristics (for example, the use of a 'statistically representative sample' in a survey).
- Representation as 'acting for': representation which entails speaking and acting on behalf of a given constituency, regardless of mode of appointment or demographic characteristics (for example, an appointed employee representative on a Health Board).

Any given public involvement mechanism will involve one or more of these types of representation, but it is helpful to distinguish between making a Board more descriptively representative of the population, or strengthening formal representation by making the Board answerable to the public.

Why?

3.6 Concerns to involve the public are often particularly acute in systems with a health service funded by general taxation and provided by the state. In private or social insurance systems, patients are more likely to be able to express their preferences via 'exit' (Hirschman, 1970), simply, by taking their business elsewhere. Nonetheless it is possible to distinguish two rationales for public involvement within a National Health Service. Martin (2008) describes these as democratic, or technocratic. Technocratic rationales suggest that empowered service users make better decisions for the public service in question, particularly as health professionals are recognised as fallible, and the citizenry as increasingly well-educated and with greater access to information (Coulter, 2002). Democratic rationales assert that as a tax-funded universal public service, health services should be accountable to the citizenry, whether via their elected representatives or through specially designed public involvement. Abelson and Eyles (2004) suggest a third rationale for participation in health care specifically, which is the development of more educated (and, implicitly, more responsible) service users.

Conclusion

3.7 These debates highlight the complexity of public involvement in health bodies. There are many potential models of involvement, groups to involve, and indeed aims for involvement. There is no clearly superior option and there will be trade-offs involved in the decisions. For example, time-consuming methods might produce more accountability but exclude the time-poor, majoritarian democracy might not represent minority opinions, and broad-based 'engagement' might include much of the population but offer little empowerment. The goal of greater public participation needs to be defined with some specificity, and matched with appropriate mechanisms to avoid disappointment.

4 ELECTED HEALTH BODIES

4.1 This section reviews the evidence on elections to health bodies. The evidence on elected health bodies in Canadian provinces is patchy. There is more comprehensive evidence on England and New Zealand, and in these cases evidence will be summarised under the following headings:

- the elections
- the relationship between the Board and the public
- the level of influence elected members had
- evidence relating to elected Board effectiveness.

Canada: Regional Health Authorities

4.2 Canadian health services have a long history of public participation, and there is an extensive body of evidence from various periods. As part of a major programme of 'regionalisation' during the 1990s, all the Canadian provinces except Ontario devolved more decision-making power to local organisations. One of the main goals of this process was enhanced public involvement (Maddalena, 2006), and in many cases this involved considering elected Boards at regional level. However only a few provinces actually instituted elections, and all have since abandoned them for appointed Boards. Reasons given for this include the financial costs of elections and the need to ensure a particular skills mix on Boards. One commentator summarised the Canadian experience with elected Boards thus:

> *"On one hand, such elections will not fracture accountabilities but will increase democracy. On the other hand, elections constitute an expensive additional process that will hardly change board outcomes and, besides, 10% voter turnout is not really democracy."* (Lomas, 2001, p. 356)

One 1999 Canadian study commissioned to advise on governance models for new health bodies concluded strongly:

> *"Preference for appointed members over elected members is overwhelming, in the specialized literature as well as in the opinions of key informants. The only question is whether appointments should be made by central authorities, by the board itself, or both ways."* (Forest, Gagnon, Abelson, Turgeon, & Lamarche, 1999, p. 4)

4.3 While Canada's experiments with elected Boards are much discussed, it has been a struggle to identify primary research evidence. The research that does exist struggles to distinguish effects of election from the wider context of health reforms. Four provinces other than Saskatchewan have had elected Health Boards. However no primary research evidence was identified on these cases. New Brunswick had elected Regional Health Authorities between 2004 and 2008. In the 2004 election, 110 candidates stood for 53 positions. 74.5% of candidates, and 72% of those elected, were male. Election turnout was 47% (Office of the Municipal Electoral Officer, 2004). In 2008, after only one election, the Regional Health Authorities were merged into a smaller number of RHAs with fully appointed Boards in 2008. The decision was justified by the need for particular skills for Board membership

"In keeping with the best practices in corporate governance and the greater need for specific expertise to manage the significantly enlarged RHA organizations, the board members of the new RHAs will be selected on the basis of required skills and competencies as well as geographic, linguistic and gender considerations." (Province of New Brunswick, 2008, p. 22)

Alberta's Regional Health Authorities had 2/3 elected and 1/3 appointed members from 2001 but since 2004 all members have been appointed by the Minister (Government of Alberta, 2004). Quebec's Regional Health and Social Service Boards were elected until 2001 (Abelson et al., 2002). Prince Edward Island elected its Regional Health Authorities until their dissolution in 2005 (Elections Prince Edward Island, 2009; PEI Health Governance Advisory Council, 2009).

Saskatchewan

4.4 Saskatchewan created Regional Health Authorities in 1992 and moved to a system of partially elected Boards in 1995. Two thirds of each Board were elected on a ward basis, and one third appointed. Three elections took place, at the same time as municipal elections.

Year	Acclaimed candidates (no election due to lack of candidates)	Voter turnout	District election costs (GBP)[1]
1995	30% (69/232)	33%	477,748
1997	68% (85/125)	25%	244,439
1999	65% (82/127)	10%	242,656

Table 2: elections for Saskatchewan RHAs: candidates, turnout, costs (Saskatchewan Health, 2001, p. 59).

4.5 There were concerns about elected Boards being captured by sectional interests who would make decisions against the general good of the population (Lomas, 2001). The Saskatchewan model was unusual for its decision to neither prohibit nor discourage health care providers standing as candidates: 47% of Lewis *et al*'s survey of Board members were or previously had worked for a health care provider (S. J. Lewis, et al., 2001). However there was no evidence that elections had particularly politicised the Boards. 25% of respondents felt that their role was most like that of a school board member, compared to 14% who felt it was most like a member of a legislature (S. J. Lewis, et al., 2001). 91% of respondents indicated that they would support a decision they believed to be right, even if it were opposed by the community, and 30% felt that their input to the Board was not strongly influenced by people in the community (S. J. Lewis, et al., 2001). A significant majority of respondents felt mostly accountable to all resident in the district (76% of respondents): but elected members were more likely than appointed members to feel most accountable to residents of their ward (S. J. Lewis, et al., 2001). Overall, Lewis *et al* (2001, p. 346) found

"surprisingly few differences in perception between elected and appointed members".

[1] Converted from Canadian dollars at 17th September 2010 exchange rate for illustrative purposes (£1 = $1.61)

4.6 Frustration about a lack of Board autonomy was a notable finding. 76% of all respondents (82% of elected and 64% of appointed members) agreed that Boards were legally responsible for things over which they had insufficient control, and 64% of elected respondents agreed they had less authority than they had expected when districts were formed (S. J. Lewis, et al., 2001).

4.7 One research project on the experience of the Saskatchewan elected Boards concluded that

> *"Neither the worst fears nor the highest hopes have been realised"* (S. J. Lewis, et al., 2001, p. 347).

In 2001 it was announced that the overall number of RHAs would be reduced, and their Boards would be fully appointed. The announcement was explained as follows:

> *"This system has been costly and not very popular. With few candidates coming forward for elected positions, and poor voter turnout, board elections have not proven to be an effective way to involve the public."* (Saskatchewan Health, 2001, p. 59)

England: Foundation Trust Boards of Governors

4.8 Foundation Trusts (FTs) were created in 2004. They have an unusual governance structure consisting of a membership made up of local people, who then elect a Board of Governors (UK Department of Health, 2009). Policy documents described this structure as modelled on "co-operative and mutual traditions", but commentators argue there is no evidence that FTs have fulfilled this brief (Allen et al., 2012; Wright, Dempster, Keen, Allen, & Hutchings, 2011). FTs operate under 'earned autonomy', with their Board of Directors held to account by this Board of Governors, rather than the Strategic Health Authority (Dixon, Storey, & Rosete, 2010). Each Foundation Trust has discretion in how to arrange both membership and elections, resulting in considerable diversity of method and Board structure (Day & Klein, 2005). However certain statutory provisions exist (House of Commons - Health Committee, 2008) including:

- Governors appoint the Chair and non-executive members to the Board of Directors
- Governors can dismiss the Chief Executive with a 75% vote
- Boards of Governors consist of a majority of elected members (both staff and public/patient) and a minority of appointed stakeholder members (from Primary Care Trusts etc).

Ham and Hunt (2008) found considerable variation in Boards of Governors. Their study of six FTs found sizes varying from 21 to 50, with most around 30 members.

Elections

4.9 As FTs can define their own model of membership and election it is difficult to draw conclusions about the finer details of models. In research conducted as recently as 2011, FTs reported an ongoing process of development of their

representative structures (Allen, et al., 2012). Day and Klein's (2005) study of the first year of FTs identified a range of options

- whether to use constituencies or not (and type – whether geographical or of interest)
- electoral system (although most used Single Transferable Vote)
- the age of eligibility of membership (from none at all to 18).

One FT chose to use an 'opt-out' model of membership – all local residents were automatically members unless they chose to opt-out – which created an unusually large membership, and an unusually low election turnout (Day & Klein, 2005).

Election turnout has fallen from 48% average in 2004, to 25% in 2011 (Monitor, Electoral Reform Research, & Member Engagement Services, 2011). One study noted that specialist FTs (such as the Royal Marsden) tend to achieve higher election turnouts (Ipsos MORI, 2008). The number of candidates per seat has fallen slightly, and the number of uncontested elections has increased from 24% to 47% between 2004 and 2011 (Monitor, et al., 2011).

In terms of the characteristics of Governors elected, Day and Klein's early study noted high numbers of retired Governors and of Governors who have at some point worked in the NHS (Day & Klein, 2005).

Public engagement

4.10 The public role of Governors is slightly unclear. In one survey, 28% of Governors who responded hadn't been involved in any 'engagement' activities (Ipsos MORI, 2008). In two studies, the question of whether Governors should hold surgeries (in the way an MP or councillor might) had arisen (Ham & Hunt, 2008; R. Lewis & Hinton, 2008). Ham and Hunt (2008) found that while in some FTs governors were holding constituency meetings, these tended to attract only small numbers of the public. In other FTs governors had not felt confident or knowledgeable enough to do so, and in some the FT had taken the view that governors should not hold surgeries (Ham & Hunt, 2008). Allen et al (2011) found evidence of informal links between governors and the public membership, such as visits to community fairs, and found that governors often saw themselves as a conduit between public and organisation (Wright, et al., 2011).

4.11 Both Lewis and Hinton (2008) and the Healthcare Commission (2005) found that the new governance arrangements had encouraged FTs to be more open to the public, including holding well-attended public meetings. One study found that FTs made significant investments of time and money and energy to engage with its membership (Allen, et al., 2012). However the Healthcare Commission also commented that too few FTs had made specific efforts to engage traditionally poorly represented groups (Healthcare Commission, 2005, p. 9), and criticised the practice of FTs moving to hold their Board of Director meetings in private (Healthcare Commission, 2005, p. 40).

4.12 Three studies highlighted the confusion caused by multiple channels of public influence (via membership, Governors, Public and Patient Involvement Forums/LINks and local authority Overview and Scrutiny Committees) (Dixon,

et al., 2010; Ham & Hunt, 2008; Healthcare Commission, 2005). Ham and Hunt (2008) argued that the removal of other channels would strengthen the role of members and Governors, but reported that some interviewees within FTs saw multiple routes of public influence as an advantage.

Influence

4.13 The studies by Dixon, Storey and Rosete (2010) and Lewis and Hinton (2008) agree that Governors have not played a very influential role. Allen et al (2012) highlight very mixed views from Governors on their own influence, ranging from having more influence than expected, to feeling excluded from key business and not given access to papers. However Dixon, Storey and Rosete (2010) and Ham and Hunt (2008) agree that the statutory powers of Governors, especially around appointments and dismissal, 'protect' their status. The potentially large number of Governors on any given Board suggests that Boards of Governors are intended as advisory, not decision-making bodies (Day & Klein, 2005). Lewis and Hinton agree, and point out the challenges of evaluating an aim as modest as Boards of Directors 'listening to' their Governors (R. Lewis & Hinton, 2008).

4.14 As well as elected Governors internal influence, several studies highlight the extent to which FTs are limited by their external accountabilities (Klein, 2003). Formally, FTs are accountable not only to their Board of Governors but, in the terms adopted by Dixon, Storey and Rosete (2010)

- 'vertically' to Parliament
- 'diagonally' to both Monitor and the Care Quality Commission
- 'horizontally' to LINks and Overview and Scrutiny Committees .

The same study found that in practice, Strategic Health Authorities also continued to hold FTs to account informally, and concluded:

> *"Contrary to the major policy objectives of giving greater autonomy to FTs and making them more accountable to the local population, FTs continue to look up rather than down."* (Dixon, et al., 2010, p. 88)

Effectiveness

4.15 The role of the Board of Governors is different from that of a more familiar Board of Directors. In their case study Lewis and Hinton found that Governors performed a range of roles, but were not involved in day-to-day management (R. Lewis & Hinton, 2008). One Board Chair categorised potential activities as guardianship, ambassadorial, statutory/constitutional and advisory (Ham & Hunt, 2008). In a later study, it was found that governors were basically effective in fulfilling their role in holding directors to account (Wright, et al., 2011). Lewis and Hinton found some disagreement between Governors and Directors over their appropriate role in decision-making, with some Governors keen to take strategic control, while others, and most Directors, preferred the Board of Governors to focus on 'patient experience' (R. Lewis & Hinton, 2008). Day and Klein's early study identified some "meddling" with operational matters such as car parking and cleanliness, and suggest that this may be inevitable given Governors' likely concern with the 'end product' of patient

experience (Day & Klein, 2005). Governors have a fairly hands-off role, with most choosing not to attend meetings of the Board of Directors (Ham & Hunt, 2008). Only 20% of Governors attend 'all or most' meetings of the Board (Ipsos MORI, 2008). Elected Governors attend more meetings than appointed (stakeholder) members (Ipsos MORI, 2008).

4.16 Turning to Governors' own assessment of their effectiveness, 27% declined to answer the survey question 'What would you say have been your main achievements as a Governor?' This is interpreted by the report's authors as uncertainty (Ipsos MORI, 2008). In another question Governors listed improved communication and better engagement as the main improvements to the FT (although only 7% and 6% respectively agreed) (Ipsos MORI, 2008). However Governors were happy with the support they received from their FT. 90% of respondents felt that their Trust kept them very well or well informed and find the Board of Directors approachable (Ipsos MORI, 2008), and 77% were very or fairly satisfied with the training and induction they had been offered (Ipsos MORI, 2008).

4.17 Ham and Hunt reported some initial tension between Governors and Directors around the role of Governors in appointments and remuneration, but found that FTs tended to move past this (Ham & Hunt, 2008). Ipsos MORI reported one Chair doubting whether Governors were 'up to' the job of selecting Non-execs, considering them to be 'amateurish' (Ipsos MORI, 2008). All studies agree that the role of Chair (a dual role chairing both the Board of Governors and of Directors) is particularly crucial to the success of FT governance (Ham & Hunt, 2008).

4.18 The Healthcare Commission report also found that many Non-Executive Directors felt that the existence of elected governors relieved Directors of the responsibility of "representing the local community", and left them able to focus on strategic decision-making (Healthcare Commission, 2005, p. 42). The Audit Commission (2009, p. 2) agreed that

> *"the introduction of FTs has generally reinvigorated governance processes and resulted in the recruitment of non-executives with a greater knowledge of effective risk management and board challenge drawn from private sector experience."*

New Zealand: District Health Boards

4.19 District Health Boards are responsible for arranging all health services for their populations, and additionally own and manage public hospitals. Direct elections to District Health Boards were instituted in 2000 (New Zealand Ministry of Health, 2010). There had previously been directly elected Area Health Boards for a spell in the 1980s (Cumming & Mays, 2002); the switches away from this model, and back again, were driven by changes of Government (Ashton, 2001; Ashton, Mays, & Devlin, 2005). District Health Boards have up to 11 members, seven of whom are elected and four appointed by the Minster of Health, with the intention of enhancing the skill base and community representation of the Board. Through this mechanism, it is ensured that at least two Board members are of Maori origin. It is stated in the legislation that

although Board members are elected, their primary accountability is to the Minster for Health. The 2000 Act created additional duties for Boards to hold Board meetings in public and to consult on strategic items (Tensenbel, Cumming, Ashton, & Barnett, 2008).

Elections

4.20 The model of elections has changed across the elections, with Single Transferable Vote (STV) optional in 2001 and then compulsory from 2004 (Gauld, 2005). In the first election (2001) a high number of candidates stood (Gauld, 2011). This has dropped off significantly in the next two. Gauld states that there is no clear reason for this, but proposes disenchantment with the system, or simply a reduction in the initial excitement as potential explanations. 80% of incumbents stood again in 2004 (Gauld, 2011). Election turnout has remained fairly high, dropping to 43% in 2007 but increasing again to 49% in 2010 (Department of Internal Affairs, 2011).[2]

	2001	2004	2007	2010
Voter turnout (%)	50	46	43	49
Candidates per seat	7.4	3.5	2.9	2.7

Table 3: New Zealand DHB elections: turnout and candidate numbers (Department of Internal Affairs, 2011)

4.21 Gauld suggests that the influence of postal voting contributes to these strong results. Gauld's 2007 post-election survey explored non-voters' rationales, and found the most common reasons were

- 'don't know' (35%)
- 'didn't know about elections' (19%)
- 'didn't receive voting papers' (12%)
- 'no interest in elections' (17%)

Interestingly, the proportion choosing 'no interest in elections' had fallen from 30% in 2004. In 2007 voters made their decisions on candidates by

- using candidate profiles (64%)
- looking for someone they know (27%)

Only 3% had 'guessed'. The qualities sought in a candidate have remained fairly stable across the three elections, with healthcare experience proving most popular (56% in 2007) and management or finance experience far less so (7% in 2007) (Gauld, 2011).

4.22 Representation of the Maori population is a major issue in New Zealand. Four members of DHBs are appointed, and this is intended in part to deal with under-representation of Maoris through elections (Gauld, 2011). Maori representation through the elections did improve after the full introduction of STV in 2004 (Barnett & Clayden, 2007). This followed a Government campaign to encourage Maori to stand as candidates and vote (Alliston &

[2] It is important to note that New Zealand turnout figures include blank, spoiled, and invalid papers which are returned. The numbers casting valid ballots are significantly smaller. It is also common for electors to be asked to vote in several different elections on the same ballot paper. For example, an elector may be asked to vote for Health Board members on the same piece of paper as for a local mayor and councillors; this is likely to affect turnout.

Cossar, 2006). Nonetheless the proportion of elected members of Maori ethnicity was 8% in 2004 and 2007 (Gauld, 2011). The total population identifying as Maori in the 2006 census was 14.6% (Statistics New Zealand, 2006).

Public engagement

4.23 Barnett and Clayden found that the combination of elected members and public Board meetings did prompt a cultural change towards openness (Barnett & Clayden, 2007). Although interviewees acknowledged that speaking out in public could compromise Board members, they felt this was part of learning a new way of working. Board meetings became slower moving, with the need to explain and reiterate for members of the public present (Barnett & Clayden, 2007).

4.24 Barnett and Clayden found that Boards had very variable ways of engaging with their public. Methods included a public right to speak at Board meetings, and public road shows (Barnett & Clayden, 2007). In addition, DHBs were encouraged to create special mechanisms to consult with their Maori population, including agreements with existing Maori bodies (Alliston & Cossar, 2006) (Boulton, Simonsen, Walker, Cumming, & Cunningham, 2004). However where community engagement had improved, Barnett and Clayden found no evidence that this was as a direct result of elected members (Barnett & Clayden, 2007). Gauld similarly concludes that

> *"the New Zealand experience … indicates that electoral mechanisms may play only a limited role in promoting participation, and could possibly counter public involvement…an elected board may be but one of multiple, parallel methods for public participation."* (Gauld, 2011, p. 9)

Tenbensel et al agree, arguing that

> *"responsiveness to central government strategies has far outweighed the representation of local communities in decision making"* (Tenbensel, Mays, & Cumming, 2011, p. 245).

Influence

4.25 Although Barnett and Clayden found some evidence of elected members having to struggle with management to gain access to strategic decision-making (Barnett & Clayden, 2007), the literature clearly suggests that the main barriers to the effective influence of elected members are constraints imposed on Boards by central Government. Despite Boards spending time on prioritisation exercises, one study found

> *"DHBs often lacked confidence that they could act on prioritisation even if they wanted to, because they would not get such decisions past central government and/or the local community."* (Tensenbel, et al., 2008)

Gauld found that some elected members presented themselves to their constituents as mere "Government messengers" (Gauld, 2011). Barnett and Clayden similarly emphasise a lack of scope for District Health Boards to exert strategic direction (Barnett & Clayden, 2007), and Ashton discusses

situations where Ministers have reversed DHB decision, undermining elected members (Ashton, 2005). Most Board members see planning as developing a local version of national strategic plans (Tensenbel, et al., 2008), and accordingly influence is more likely to be over issues around service design and delivery. The consensus seems to be that the shift to local decision-making has been outweighed by other policy trends:

> *"Despite the formal organisational shift to local (i.e. DHB level) decision-making, the pressure in the opposite direction to hold local agencies accountable for their use of public funds has, if anything, increased over time."* (Ashton, et al., 2005)

Effectiveness

4.26 The literature identifies a steep learning curve for new elected members. Chief Executive Officers reported a lack of technical skills in some cases, with particular gaps around financial management (Barnett & Clayden, 2007). However they also stated that they valued new members' strong networks and community contacts (Barnett & Clayden, 2007). Chairs talked about the hard work put in to equip new members with the necessary skills, and Barnett and Clayden conclude that

> *"While Boards may not be seen to have the necessary skills, and the ability to fill those skills gaps through appointment was constrained, the notion of Board development is strongly present. When accompanied by good leadership and supportive management the capability of the Boards can clearly be raised to appropriate levels."* (Barnett & Clayden, 2007)

While there is some evidence of early tensions between management and elected members, with the careful management of Chairs, effective team-working was achieved in most cases (Barnett & Clayden, 2007)

4.27 Elections to health bodies have been held in a number of systems: in some Canadian provinces in the 1990s; in New Zealand in the 1980s and again since 2000; and for Foundation Trusts in England since 2004. Voter turnout for these elections is generally disappointing, and tends to fall over time, along with numbers of candidates. The extent to which elected members engage with the public varies, but in some cases the presence of an elected Board seems to encourage organisational openness and transparency. Elected members often have a different skill-set from previously appointed members, and experience a steep learning curve. Notably, in each instance of elections, research has found that elected members are surprised and often frustrated by the lack of autonomy their boards have from central government control.

5 NON-ELECTORAL MODELS

5.1 Health systems have used methods other than direct election to try to make Boards more representative of the public. Two common models are appointed representatives on Boards and advisory committees (Frankish, Kwan, Ratner, Wharf Higgins, & Larsen, 2002). There is limited empirical evidence on alternative appointment processes. There is more evidence on advisory bodies, particularly from UK health systems and Canadian provinces. Three models from within the UK are also discussed in this chapter, chosen to illustrate contrasting models.

Board appointments

Quebec: hospital Boards

5.2 In the 1970s, Quebec attempted to democratise the Boards of its hospitals by setting quotas for the representation of different groups on its Boards. This was to include two patients, two representatives from local business or civic organisations, four members of the hospital's Corporation (often former Board members), one health professional (nurse), one physician, and one member of non-professional staff (Eakin, 1984).

5.3 In the resulting Boards the percentage of members with a background in business and finance declined from 56% before the reforms to 17% afterwards (Eakin, 1984). One study of the reforms found that technical decisions became slower because there were more perspectives present, and administrators (managers) felt that new members lacked basic committee and administrative skills (Eakin, 1984). Much of the decision-making shifted away from meetings of the full Board to individual contacts and social environments (for example, the local golf club) where the new 'lay' representatives on the Board weren't present (Eakin, 1984).

England: Primary Care Trust Boards

5.4 In June 2009 the Government set targets that for all new public appointments, including for the Boards of Primary Care Trusts:

- 50% should be women,
- 14% should be disabled people,
- and 11% should be Asian, Black or Minority Ethnic (Appointments Commission, 2010b).

The Appointments Commission uses a number of approaches to increase the diversity of members of local NHS Boards in England. Research with existing female public appointees suggested that a lack of time was one of the greatest challenges faced, and identified factors that attracted women to apply (Appointments Commission, 2009). A new advertising strategy for candidates was designed with these findings in mind (Appointments Commission & Department of Health, 2010). Other techniques have included maintaining a database of "near hit" candidates who aren't initially successful, in the hope of supporting them into later opportunities (Appointments Commission & Department of Health, 2010). No primary research was identified on this

process, and the Appointments Commission statistics on application and appointment do not show significant improvement across the categories of diversity at this early stage (Appointments Commission, 2010a). Subject to the passage of current NHS reforms in England, the Appointments Commission, which has been responsible for these campaigns, will be abolished in October 2012.

Advisory bodies

England: Community Health Councils

5.5 Community Health Councils were created in the 1974 reorganisation of the NHS to formalise public involvement (or 'consumer representation') while separating it from the day-to-day running and management of health services (Klein & Lewis, 1976). These independent bodies were set up "to represent the views of the consumer" (Great Britain Ministry of Health and Social Security, 1970), with their membership appointed by local authorities, Regional Health Authorities and local voluntary organisations.

5.6 CHCs had a wide remit, including collecting information from users and collecting information about services; for example by commissioning small-scale local research (Ham, 1980). Area Health Authorities had to consult their CHCs about proposed hospital closures (and if they agreed, there was no need for approval from the Secretary of State). There was great variety in the actual activities of CHCs, with one national survey suggesting five roles in practice, ranging from closely cooperative "Health Authority Partner Councils" to "Independent Challengers", who were mostly excluded from decision-making (Lupton, Buckland, & Moon, 1995). Overall, CHCs were not found to have a great impact on their Health Authorities (Lupton, et al., 1995). As early as 1975, one survey of health service administrators found that:

> *"Administrators felt that CHCs had power without responsibility; that they were unrepresentative; and that they were unwilling to do the background work on problems referred to them."* (Ham, 1980, p. 295)

As the NHS was reorganised, various other units were increasingly seen as representing service users (Pickard, 1997). CHCs were eventually abolished in 2003.

England: Local Involvement Networks (LINks)

5.7 In 2008, new organisations known as LINks began operating in every local authority area in England. Their aim is "to provide flexible ways for communities to engage with health and social care organisation in ways that best suit the communities and the people in them" (NHS National Centre for Involvement, 2007). A key element of this model is the attempt to create space for involvement across the whole patient pathway, including primary, secondary and social care.

One evaluation of so-called 'early adopter' sites, which began to develop their LINks in 2007 found that;

- LINks felt under-funded. Initial costs of setting up the networks varied from £3412 to £10949 excluding staff costs.
- Some actors were concerned that Local Authorities would try to control the LINks (Taylor & Tritter, 2007)

A later research project found that LINks were largely doing a good job of outreach and had achieved a fairly demographically diverse membership, but that they were felt to be lacking strategic vision for their activities (Dorfman, Batty, Campbell, Chapman, & Newman, 2010).

Both of these reports are largely concerned with setting up new LINks, and there is a lack of research evidence about the working of this model. Some commentary discusses the options available for the governance of LINks (namely the choice between a network model, a steering group model, or a combination of the two) but is not based on empirical research with LINks (Mullen, Hughes, & Vincent-Jones, 2011). Current proposed reforms of the NHS in England include LINks changing to local 'HealthWatch' organisations (Wise, 2011).

Scotland: Public Partnership Forums

5.8 Public Partnership Forums have existed since 2004, when they were required in every Community Health Partnership (CHP) in Scotland. The model is one of local flexibility but statutory guidance defines three roles:

- "ensure that the CHP is able through the PPF and other means to inform local people about the range and location of services and information which the CHP is responsible for"
- "engage local service users, carers and the public in discussion about how to improve health services"
- "support wider public involvement in planning and decision making and to seek to make public services more responsive and accountable to citizens and local communities" (Scottish Executive, 2004)

5.9 Identified research evidence on Public Partnership Forums is limited to a report commissioned by the Scottish Health Council and published in 2007 (FMR Consulting, 2008). This report found that PPFs became established quickly, particularly where they had been built on existing structures. However much of their activity focussed on establishing their own structures. The report authors found that substantial variation in form of Forum

> *"reflects the diverse geographical and social make up of different areas, different existing community involvement structures and also different attitudes towards public involvement."* (FMR Consulting, 2008, p. 99)

Most PPF members had previously been involved in other community/ voluntary sector activities, and this was a cause for concern from some quarters. However the report authors also highlighted the depth of experience and knowledge this gave to Forums. Lack of awareness of PPFs in the wider public was seen as a key challenge, but most PPF members felt they had good relationships with their Community Health and Care Partnership and were being listened to.

5.10 Instead of holding direct elections for members of health bodies, some systems have sought to improve public representation by making changes to the recruitment and appointment process for Board members, or by creating forums for members of the public to advise conventionally-appointed Boards. Appointed Boards in Quebec were given quotas for representation of different groups in the 1970s, but the impact of these appointees was found to be limited. Boards of Primary Care Trusts in England have had targets for the representation of different groups since 2009, and there is a lack of research on how effective this has been. Advisory bodies have been a common feature of health systems in the UK, although research evidence is largely concerned with Community Health Councils, which were abolished in 2003. As advisory bodies are generally self-selecting groups, they may not be seen as representing the public. Evidence suggests that it can be challenging for these groups to strike a balance between conducting outreach and public engagement work, or working to influence Boards on strategic matters.

6 CONCLUSION

6.1 Public involvement is a particular challenge for health services which are provided by the state and funded by general taxation. A wide range of models and activities exist, and each will have particular strengths and weaknesses in different settings. This literature review presents research evidence on methods of improving public representation on Health Boards: direct elections, alternative modes of appointment, and advisory committees. While there is a substantial literature on these topics, it does not necessarily offer evidence neatly packaged to inform policy-making. As others have acknowledged (Barnett & Clayden, 2007), the primary research on Board elections mostly focuses on the views of Board members and so it is difficult to identify wider impacts. This reflects a broader preoccupation in the literature with accounts of process rather than assessments of outcomes (Mitton, Smith, Peacock, Evoy, & Abelson, 2009). Even where research looks at outcomes, the absence of objective measures of community engagement, and the problems with attributing outcomes to specific initiatives, mean that conclusions are rarely as clear as we might like (S. J. Lewis et al., 2001).

6.2 The most directly comparable examples of direct elections to health bodies are some Canadian Regional Health Authorities (RHAs), New Zealand District Health Boards (DHBs), and Foundation Trusts in England. Evidence from these systems suggests that elections are not in themselves sufficient to ensure a high quality or quantity of public involvement. However once in place, fears that elected Boards will harm health services due to a lack of experience or to 'political interference' do not appear to have been realised. Indeed, once in place, elected Board members have similar views to appointed Boards. However the more public role of elected Board members can raise expectations about the degree of influence they have. Boards often focus mainly on day-to-day management, with strategic policy-making remaining with central or provincial Government. In both New Zealand and Canada elected members were frustrated by these limitations on their influence. Where elections have been tried and then abandoned, as in Saskatchewan, it has generally been justified by reference to low turnout and financial cost, rather than to evidence of problems with Board functioning.

6.3 One alternative to elections is to alter how Board members are recruited and appointed. There is a lack of research evidence on these techniques, but models which have been used include:

- Quotas (Quebec hospital boards in the 1970s, New Zealand District Health Boards) or targets (Primary Care Trust Boards in England) for the representation of particular groups on Boards.
- Rethinking advertising campaigns and supporting 'near hit' candidates to reapply (Primary Care Trust Boards in England)

6.4 There are many examples of advisory bodies in the UK and in Canada, including Scotland's current system of Public Partnership Forums. Some themes from the literature include:

- Advisory bodies are sometimes criticised for being weak, as by definition they don't have direct decision-making control. It can be difficult to evaluate their level of influence.
- As with appointed Boards, questions of representation arise repeatedly with advisory bodies. People with the confidence and time to take part are often older, and more middle class. Ethnic minorities and young people are often under-represented. Models of 'drop-in drop-out' participation such as LINks in the English NHS are seen as a solution to this, but have other drawbacks.

6.5 International experience shows that neither elected nor advisory bodies can resolve all of the challenges of patient and public involvement. Problems of low or intermittent engagement, questions about representativeness, and the cost-effectiveness of any given strategy are common and do not seem to have any one solution.

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